TEXAS DIABETES PROGRAM/COUNCIL
DIABETIC EYE DISEASE PROGRAM

NOMINATOR APPLICATION

PLEASE PRINT

NAME: _____
(Last) (First) (Middle)

TITLE: _____

FACILITY/CLINIC: _____

ADDRESS: _____
(#, Street or POBox)

_____
(City) (State) (Zip)

TELEPHONE: ( ) _____ FAX: ( ) _____

E-MAIL: _____

COUNTY: _____ TDH REGION: _____

Estimated number of clients to be referred by you for an Eye Exam

within the next 12 months: _____

Sign below to confirm that you have read and understand the information in the nominator application guidelines:

SIGNATURE: _____ DATE: _____

Return to: Texas Diabetes Program/Council
Texas Department of State Health Services
1100 W. 49th Street
Austin, Texas 78756-3199

NOTE: PLEASE CALL (512) 458-7111 EXT. 2833 FOR ASSISTANCE OR QUESTIONS.